U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 November 2006

CASE NO.: 2005-BLA-5139

In the Matter of:

F. J. O.,
Claimant

v.

PEABODY COAL COMPANY,
Employer

And

OLD REPUBLIC INSURANCE COMPANY,
Carrier

And

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

S. F. Raymond Smith, Esq.,
For the Claimant

Paul E. Frampton, Esq.,
For the Employer

BEFORE: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION DENYING BENEFITS

This proceeding arises from a miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, as amended ("Act"), filed on July 2, 2001. The act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his claim for benefits on July 2, 2001. (Director's Exhibit ("DX") 2). On April 25, 2002, the claim was denied by the district director because the evidence failed to establish that Claimant was totally disabled due to pneumoconiosis. (DX 20). Thereafter, on April 29, 2002, Claimant, through counsel, requested a formal hearing before the Office of Administrative Law Judges. (DX 21).

Administrative Law Judge Leland issued a Decision and Order – Denying Benefits, dated January 8, 2004. (DX 41). Judge Leland found Claimant totally disabled due to a pulmonary impairment. He, however, also found that Claimant did not prove the existence of coal workers' pneumoconiosis. As such, benefits were denied. (DX 41). Thereafter, on January 26, 2004, Claimant, through counsel, requested modification of the denial of benefits. In support of his request, Claimant submitted a January 18, 2004 chest X-ray interpreted by Dr. Aycoth. (DX 44).

On July 26, 2004, the District Director issued a Proposed Decision and Order Denying Request for Modification. (DX 45). Claimant disagreed with the District Director findings and requested a formal hearing before the Office of Administrative Law Judges. (DX 46). I was assigned the case on January 3, 2006.

On May 11, 2006, I held a hearing in Beckley, West Virginia, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Director's exhibits ("DX") 1-50 and Employer's exhibits ("EX") 1, 3-6[2] were admitted into the record. Claimant's counsel and Employer's counsel submitted closing briefs post-hearing for my consideration.

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] Employer's Exhibit 2 was not admitted into the record due to exceeding the evidentiary limitations of § 725.310.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a mistake in a determination of fact?

VI. Whether there has been a material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 25 years, as stipulated by the parties. (Hearing Transcript (TR) 11).

B. Date of Filing[3]

The claimant filed his request for modification, under the Act, on January 26, 2004. None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[4]

Peabody Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G, Part 725 of the Regulations.

[3] 20 C.F.R. § 725.310 (For Modifications) provides:

(a)…the director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

[4] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

D. Dependents

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife. (DX 2).

E. Personal, Employment and Smoking History

The claimant was born on June 3, 1940. (DX). Claimant's last position in the coal mines was that of a slate truck driver. Prior to being a truck driver, he worked in the mines underground. (DX; TR).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. Claimant began smoking at age 16. He smoked almost one pack of cigarettes per day, quitting in 1974.

II. Medical Evidence

A. Chest X-rays[5]

There were eight readings of four X-rays, taken on September 26, 2001, November 14, 2001, January 19, 2004 and December 28, 2005. Two are positive, by two B-reader physicians, Drs. Aycoth[6] and Zaldivar.[7] Five are negative, by four physicians, Drs. Forehand, Scott, Wheeler and Scaterige, all of whom are either B-readers, Board-certified in radiology, or both. Dr. Binns provided a quality only reading of the September 26, 2001 chest X-ray.

Exh. #	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 8	9/26/2001 9/26/2001	Dr. Forehand	B	1		Negative.
DX 11	9/26/2001 11/2/2001	Dr. Binns	B, BCR	2 - dark		Quality only reading.
DX 34	9/26/2001 4/25/2003	Dr. Scott	B, BCR	2		Negative.

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e) (effective Jan. 19, 2001).

[6] Dr. Aycoth's qualifications are not in the record. He was previously registered as a B-reader. I am assuming that his certification is up to date based on his prior B-reader experience.

[7] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n.16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993)."

Exh. #	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 36	11/14/2001 11/30/2001	Dr. Wheeler	B, BCR	2		Negative.
DX 37	11/14/2001 11/14/2001	Dr. Zaldivar	B		1/1	Very early CWP.
DX 44	1/19/2004 1/19/2004	Dr. Aycoth	B	1	1/1	p/q. all zones.
EX 1	1/19/2004 1/20/2006	Dr. Scott	B, BCR	1		Negative.
EX 4	12/28/2005 2/7/2006	Dr. Scaterige	B, BCR	1		Negative.

* A-A-reader; B-B-reader; BCR – Board Certified Radiologist; BCP – Board-Certified Pulmonologist; BCI – Board-Certified Internal Medicine; BCI(P) – Board-Certified Internal Medicine with Pulmonary Medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified, as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the X-ray form, then the X-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[8]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV1) and maximum voluntary ventilation (MVV).

Physician Date Exh. #	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify* Conform**
Dr. Forehand 9/26/2001[9] DX 8	61 69"	.94 1.03+	34.17 44.44+	2.27 2.61+	Yes	Good Good	Yes, Yes Yes, Yes

[8] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

[9] Dr. Ranavaya found the September 26, 2001 studies to be acceptable. (DX 9).

Physician Date Exh. #	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify* Conform**
Dr. Zaldivar 11/14/2001 DX 37	61 70”	.75 .93+		2.95 3.58+	Yes		Yes, Yes Yes, Yes
Dr. Zaldivar 12/28/2005 EX 3	65 70”	1.12 1.20+		4.17 4.60+	Yes		Yes, Yes Yes, Yes

+ Values after the use of bronchodilators.
* A “**qualifying**” pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study “**conforms**” if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanies by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states “(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…”

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed “unacceptable” when the subject “[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1’s of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test.” (Emphasis added).

For a miner of the claimant’s height of 69.67 inches, § 718.204(b)(2)(i) requires an FEV1 equal to or less than 1.95 for a male 65 years of age.[10] If such an FEV1 is shown, there must be in addition, an FVC equal to or less than 2.50 or an MVV equal to or less than 78; or a ratio equal to or less than 55% when the results of the FEV1 tests are divided by the results of the FVC test.

[10] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are “qualifying.” *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th Cir. 1995). I find the miner is 69.67” here, his average reported height.

C. Arterial Blood Gas Studies[11]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Exh. #	Physician	PCO2	PO2	Qualify
9/26/2001 DX 8	Dr. Forehand	40 45*	63 57*	No Yes
11/14/2001 DX 37	Dr. Zaldivar	41	63	No
12/28/2005 EX 3	Dr. Zaldivar	40	73	No

* Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports[12]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Forehand, a B-reader, examined Claimant on September 26, 2001. (DX 8). Dr. Forehand noted a 20 year smoking history at one pack per day quitting in 1974. He listed Claimant's symptoms as sputum, wheezing, dyspnea, cough, hemoptysis, and two-pillow orthopnea. (DX 8).

[11] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. § 204(b)(2) permits the use of such studies to establish "total disability." It provides:

In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii) or (iv) of this section shall establish a miner's total disability:…

(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

[12] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Forehand diagnosed chronic bronchitis. He stated that the cause of Claimant's chronic bronchitis is his history of cigarette smoking. Dr. Forehand also concluded that Claimant's chronic bronchitis is totally and permanently disabling. (DX 8).

Dr. Branscomb reviewed Claimant's medical records. In arriving at his conclusions, Dr. Branscomb reviewed numerous articles of medical evidence that are not in the record. (DX 35). Dr. Branscomb diagnosed Asthma. He stated "his childhood diagnosis of asthma, his early onset of episodes of wheezing, paroxysmal cough, and nocturnal attacks are all entirely characteristic of asthma." Dr. Branscomb concluded that Claimant is totally disabled as the result of chronic pulmonary disease. He also found that his pulmonary disease was in no way caused or aggravated by coal mine dust exposure. (DX 35).

Dr. Zaldivar prepared a report, dated December 26, 2001, based upon his November 14, 2001 examination of the Claimant. (DX 37). Dr. Zaldivar is a B-reader and Board-certified in internal medicine, pulmonary diseases, sleep disorder medicine and critical care medicine. Dr. Zaldivar noted Claimant's symptoms as shortness of breath, wheezing, cough productive of sputum, and two-pillow orthopnea. Dr. Zaldivar noted 25 years of coal mine employment. He stated "[H]e had worked as a roof bolter and as a miner helper, both of which exposed him to sufficient dust to have acquired occupational pneumoconiosis radiographically which he, in my opinion, has done." Drs. Wheeler and Scott reviewed the chest X-ray taken during Dr. Zaldivar's examination. They saw changes in the right and left upper lobes and attributed the changes to an old infection such as tuberculosis. Dr. Zaldivar disagrees. He notes that Claimant has no history of severe infection or tuberculosis. (DX 37).

Dr. Zaldivar also diagnosed Claimant with asthma and emphysema. He explained that neither the asthma nor emphysema was caused by coal dust exposure. Dr. Zaldivar concluded that Claimant's emphysema is the main cause of his severe pulmonary impairment. Dr. Zaldivar found Claimant incapable of returning to his prior coal mine work due to severe lung disease. He stated "[Claimant] has simple coal workers' pneumoconiosis in my opinion and severe impairment caused by emphysema, with a component of asthma and a mild contribution by pneumoconiosis." (DX 37).

Dr. Zaldivar was deposed on May 10, 2006. (EX 6). Dr. Zaldivar testified that Claimant has an obstructive impairment. (EX 6, p. 10). He explained that it is a variable obstruction, consistent with asthma. He stated that pulmonary function studies revealed an obstructive impairment and that blood gases were within normal limits. Dr. Zaldivar concluded that the airway obstruction is due to a combination of asthma and emphysema. (EX 6, p. 14).

Dr. Zaldivar stated that bullae were present in Claimant's lungs. He explained "[T]hese are typical of smoker's emphysema or bronchiectasis or cystic fibrosis or something other than coal workers' pneumoconiosis. Coal workers' pneumoconiosis does not cause bullae and there are plenty of studies that show that." He stated that the presences of bullae reveals smoker's emphysema. (EX 6, p. 15).

In a report, dated March 12, 2003, Dr. Rasmussen discusses his findings after reviewing Dr. Forehand's report and his testing. (DX 38). He stated that Dr. Forehand based his finding of no pneumoconiosis on a negative Chest X-ray. Dr. Rasmussen explains that chest X-rays are an imperfect tool for determining the presence or absence of pneumoconiosis. Dr. Rasmussen also states that chronic obstructive lung disease can be a consequence of coal dust exposure. He concludes "[B]ased on all of the large body of medical evidence, it must be concluded that [Claimant's] disabling lung disease is the consequence both of his cigarette smoking and his coal mine dust exposure regardless of the X-ray findings." (DX 38).

Dr. Tuteur was deposed in regards to Claimant's claim on May 9, 2006. (EX 5). Dr. Tuteur is Board-certified in internal medicine and pulmonary diseases. Dr. Tuteur reviewed Claimant's medical records. Dr. Tuteur concluded that Claimant has chronic obstructive pulmonary disease. He explained "[Claimant] has exercise intolerance, chronic daily productive cough, occasional wheezing, physical exam that is consistent with COPD, a severe obstructive abnormality, no restrictive abnormality and impairment of gas exchange that worsens during exercise on several, but not all occasions." (EX 5, pp. 12-13).

Dr. Tuteur testified that Claimant's pulmonary function studies and arterial blood gas studies were consistent with and typical of chronic obstructive pulmonary disease. (EX 5, p. 15). Dr. Tuteur explained that Claimant has several potential contributing factors to the chronic obstructive pulmonary disease. He listed cigarette smoking, gastroesophageal reflux disease with hiatus hernia, asthma and coal dust exposure. (EX 5, p. 16). Dr. Tuteur concluded that a combination of tobacco smoke, reflux disease and childhood asthma caused the chronic obstructive pulmonary disease. He stated "[t]hough it is recognized that there is a slight possibility that coal mine dust may have been a contributing factor, with reasonable medical certainty, in this case, it was not." (EX 5, p. 18). Dr. Tuteur opined that Claimant's impairment would be no different had he never worked in the coal mine industry.

III. Hospital Records & Physician Office Notes

Employer submitted office records regarding treatment of Claimant by Drs. Mullins and Porterfield at Pulmonary Associates for asthma. (DX 33). On April 3, 2001, Dr. Mullins stated that Claimant presented himself complaining of shortness of breath and wheezing. Dr. Mullins prescribed a medication and planned a follow-up appointment. On April 9, 2001, Dr. Portherfield stated that Claimant had continued exacerbation of asthma. Claimant was prescribed Azmacort, Prednisone, Z-PAK, and Allegra and scheduled for a two week follow-up appointment. (DX 33).

Claimant had a follow-up with Dr. Porterfield on June 28, 2001. Dr. Porterfield found exacerbation of asthma and chronic obstructive pulmonary disease. On August, 28, 2001, Dr. Porterfield again noted asthma, acute exacerbation, and chronic obstructive pulmonary disease. Dr. Mullins noted, on January 31, 2002, that Claimant has asthma and chronic obstructive pulmonary disease. She prescribed a regimen of controlling medications. Claimant saw improvement with the medication Prednisone. (DX 33).

IV. Witness' Testimony

Claimant testified before Administrative Law Judge Leland at a September 30, 2003 hearing. Claimant was on oxygen at the hearing and testified that he has been using oxygen for approximately six years. (DX 39).

Claimant also testified at the May 11, 2006 hearing before the undersigned. (TR 7). Claimant was still on oxygen. He testified that he uses the oxygen seventeen to twenty-four hours a day. (TR 9).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501, No. 01-4604 (6th Cir. July 31, 2003).

Under 20 C.F.R. § 725.310, a modification petition may be based upon a mistake of fact or a change in conditions.[13] In determining whether a mistake of fact has occurred, the Administrative Law Judge is not limited to a consideration of newly submitted evidence. All evidence of record may be reviewed to determine whether a mistake of fact was previously made. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256, 92 S.Ct. 405, 407, 30 L.Ed.2d 424 (1971)(per curium)(decided under Longshore and Harbor Workers' Compensation Act). The Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence previously submitted." *O'Keefe*, 404 U.S. 254 at 257; *Lisa Lee mines v. Director, OWCP*, 86 F.3d 1358, 1364 (4th Cir. 1996)(*en banc*), *quoting Jessee v. Director, OWCP*, 5 F.3d 723, 724 (4th Cir. 1993). Therefore, a complete review of the record will be conducted to determine whether a mistake of fact exits.

[13] 20 C.F.R. 725.310 (Applicable to petitions for modification filed on or after Jan. 19, 2001 (65 Fed. Reg. 80057):

"(b) Modification proceedings shall be conducted in accordance with the provisions of this part as appropriate except that the claimant and the operator, or group of operators or the fund, as appropriate, shall each be entitled to submit no more than one additional chest X-ray interpretation, one additional pulmonary function test, one additional arterial blood gas study, and one additional medical report in support of its affirmative case along with such rebuttal evidence and additional statements as are authorized by paragraphs (a)(2)(ii) of § 725.414."

A review of the record does not show that there has been a mistake of fact. The claimant has failed to establish that here has been a mistake of fact.

To assess whether a change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994)("Change in conditions" not established where the existence of pneumoconiosis by chest X-ray was demonstrated in the original claim and the claimant merely submitted additional positive X-ray readings on modification); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993);[14] *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *and Kovac v. BCNR Mining Corp*., 14 B.L.R. 1-156 (1990), *aff'd on recon.*, 16 B.L.R. 1-71 (1992).

As discussed below, I find that Claimant is totally disabled due to a pulmonary condition. I also find that Claimant did not prove the existence of coal workers' pneumoconiosis. As this is the same determination as Judge Leland, Claimant has not proven a change in conditions since the prior denial of benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[15] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as

[14] *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993). Resubmission of evidence already contained in the record and previously considered by the administrative law judge cannot establish a "change of conditions," under 20 C.F.R. § 725.310, but where doctors reports are generated after the earlier denial of benefits they must be considered.

[15] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director,* 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act. In *Workman v. Eastern Associated Coal Corp*., 23 B.L.R. 1-22, BRB No. 02-0727 BLA (Aug. 19, 2004)(order on recon)(*en banc*) the Board ruled that because the potential for progressivity and latency is inherent in every case, a miner who proves the presence of pneumoconiosis that was not manifest at the cessation of his coal mine employment, or who proves that his pneumoconiosis is currently disabling when it was previously not, has demonstrated that the disease from which he suffers is of a progressive nature. In amending section 718.201, DOL concluded chronic dust diseases of the lung and its sequelae arising out of coal mine employment "may be latent and progressive, albeit in a minority of cases." *See* 64 Fed. Reg. 54978-79 (Oct. 8, 1999); 65 Fed. Reg. 79937-44, 79968-72 (Dec. 20, 2000); 68 Fed. Reg. 69930-31 (Dec. 15, 2003). "Although every case of pneumoconiosis does not possess these characteristics, the regulation was designed to prevent operators from asserting that pneumoconiosis is never latent and progressive. 20 C.F.R. Section 718.201(c); *see National Mining Association, et al. v. Chao, Sec. of Labor*, 160 F.Supp.2d 47 (D.D.C. Aug. 9, 2001) *aff'd,* 292 F.3d 849 (D.C. Cir. 2002)("NMA"), 292 F.3d at 863." *Midland Coal Co. v. Director, OWCP [Shores]*, 358 F.3d 486 (7th cir. 2004). Seventh Circuit upheld DOL's 2001 definition of CWP as a latent and progressive disease. DOL's regulation, on this scientific finding is entitled to deference. It is designed to prevent operators from claiming CWP is never latent and progressive.

anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R § 718.201.[16]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[17] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis, if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 14 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The Board has recently adopted the Director's position to hold that "a transient aggravation of a non-occupational pulmonary condition is insufficient to establish pneumoconiosis as defined at Section 718.201." *Henley v. Cowen and Co.*, 21 B.L.R. 1-148, BRB No. 98-1114 BLA (May 11, 1999).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy

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[16] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis,

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal Pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

[17] The definition of pneumoconiosis, in 20 C.F.R. section 718.5201, does not contain a requirement that "coal dust specific diseases…attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are disease whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[18] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3rd Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.*; *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 91991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-231, n.5 (1985).

As noted above, the record contains chest X-rays dated September 26, 2001, November 14, 2001, January 19, 2004 and December 28, 2005. The September 26, 2001 X-ray was interpreted by a B-reader and a dually-qualified physician. Both determined the X-ray negative for coal workers' pneumoconiosis. As there are no conflicting interpretations, the September 26, 2001 X-ray is negative for coal workers' pneumoconiosis.

Conflicting interpretations of the November 14, 2001 X-ray were submitted. A dually-qualified physician interpreted the X-ray as negative for coal workers' pneumoconiosis. Dr.

[18] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B..R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

Zaldivar, a B-reader, found the X-ray revealed very early pneumoconiosis. I accord greater weight to the interpretation by a dually-qualified physician. As such, based on the physician qualifications, I find the November 14, 2001 X-ray negative for coal workers' pneumoconiosis.

A dually-qualified physician interpreted the January 19, 2004 X-ray as negative for coal workers' pneumoconiosis. Dr. Aycoth interpreted the X-ray as positive for coal workers' pneumoconiosis. Dr. Aycoth's qualifications are not in the record. He was previously registered as a B-reader. Assuming that Dr. Aycoth is currently certified as a B-reader, I still find his interpretation entitled to less weight than the dually-qualified physician interpretation. Therefore, I find the January 19, 2004 X-ray negative for coal workers' pneumoconiosis.

Only one interpretation of the December 28, 2005 X-ray is included in the record. A dually-qualified physician interpreted the X-ray as negative for coal workers' pneumoconiosis. As there are no conflicting interpretations, the December 28, 2005 X-ray is negative for coal workers' pneumoconiosis.

In summary, I find all four X-rays negative for coal workers' pneumoconiosis. Additionally, due to the progressive nature of the disease, I find the January 19, 2004 and December 28, 2005 X-rays entitled to the greatest weight in determining the existence of coal workers' pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray, 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[19] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

As previously summarized, Drs. Forehand, Branscomb, Zaldivar, Rasmussen, and Tuteur prepared opinions regarding Claimant's condition. Dr. Forehand concluded that Claimant's pulmonary condition is due to chronic bronchitis caused by cigarette smoking. Dr. Forehand provided no rationale for this finding. Aside from referring to a negative chest X-ray and noting a prior cigarette smoking history, Dr. Forehand did not explain why smoking as opposed to coal

[19] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…" In *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4).

dust exposure caused Claimant's current condition. Due to his lack of explanation, I find Dr. Forehand's opinion entitled to little weight.

Dr. Branscomb also concluded that Claimant does not have coal workers' pneumoconiosis. Dr. Branscomb's opinion considers numerous pieces of medical evidence that are not included in the record. Due to the structure of his opinion, it is impossible to determine what his opinion is when considering only the evidence in the court record. Therefore, I find Dr. Branscomb's opinion entitled to little weight in determining the existence of coal workers' pneumoconiosis.

Dr. Zaldivar found that Claimant has coal workers' pneumoconiosis. His opinion appears to be based solely on his B-reader chest X-ray interpretation. The chest X-ray he refers to was also reviewed by two dually-qualified physicians as negative for coal workers' pneumoconiosis. Additionally, in a later deposition, Dr. Zaldivar appears to diagnose only asthma and emphysema. Both of which he concludes were not caused by coal dust exposure. Based on the rationale of his opinion and his variable deposition testimony, I also find Dr. Zaldivar's opinion entitled to little weight.

Dr. Rasmussen provided an opinion that Claimant has pneumoconiosis. His rationale is that medical studies show that a negative chest X-ray does not rule out the existence of coal workers' pneumoconiosis and that chronic obstructive pulmonary disease can be caused by coal dust exposure. Dr. Rasmussen makes statements regarding medical theories, which are not contested by the other physicians of record, but does not explain how such studies correspond to the facts of Claimant's case. He apparently states that because a person may have coal workers' pneumoconiosis without a positive chest X-ray and coal dust exposure may have caused a person's chronic obstructive pulmonary disease, then obviously it is the case with this particular Claimant. Dr. Rasmussen is providing faulty logical conclusions that have no fact specific evidence to support such conclusions. Therefore, I find Dr. Rasmussen's opinion not to be credited in determining the existence of coal workers' pneumoconiosis.

During deposition testimony, Dr. Tuteur concluded that Claimant chronic obstructive pulmonary disease that is not caused by coal dust exposure. Dr. Tuteur based his opinion on pulmonary function studies, arterial blood gas studies and Claimant's daily symptoms. Dr. Tuteur determined that a combination of cigarette smoking, reflux disease and childhood asthma contributed to Claimant's condition. He also found that coal dust exposure was not a contributing factor in Claimant's case. Due to Dr. Tuteur's explanation of the symptoms and his explanation of Claimant's contributing conditions, I find his opinion well reasoned.

Therefore, after considering the X-ray evidence and physician opinions together, I find the Claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3rd Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[20] Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc,* 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

[20] The Board has held it is the claimant's burden to establish total disability due to CWP by a preponderance of the evidence. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986)(*en banc*). 20 C.F.R. § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:
(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespirtory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. As shown in a table above, pulmonary function studies were performed on September 26, 2001, November 14, 2001 and December 28, 2005. All studies produced qualifying results for both pre-bronchodilator and post-bronchodilator tests. Thus, Claimant has proven the existence of a total pulmonary disability by pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). Arterial blood gases were also performed on September 26, 2001, November 14, 2001 and December 28, 2005. With the exception of the September 26, 2001 exercise study, none of the studies produced qualifying results. Thus, a majority of the arterial blood gas studies do not prove total disability.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204.[21] The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

Drs. Forehand, Branscomb and Zaldivar prepared opinions regarding the miner's level of impairment. All three physicians agree that Claimant is permanently and totally disabled due to a pulmonary impairment. Thus, Claimant has proven the existence of total disability based on physician opinions.

After reviewing the pulmonary function studies, arterial blood gas studies and physician opinions, I find that the evidence overwhelmingly supports a finding of total disability. Thus, I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3rd Cir. 1993).

[21] Opinion that the miner should work in a dust-free environment does not constitute a total disability finding. *See White v. New White Coal Co.*, 22 B.L.R. 1-__, BRB No. 03-0367 BLA (Jan. 22, 2004).

E. Cause of total disability

The revised regulations, 20 C.F.R. § 718.204(c)(1), requires a claimant to establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 7999946 (Dec. 20, 2000).

As I have found that Claimant does not suffer from coal workers' pneumoconiosis, the issue of disability causation is moot. Furthermore, the weight of the evidence supports a finding of disability due to asthma and smoking induced emphysema.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in conditions has taken place since the previous denial, because he has not established the existence of totally disabled due to pneumoconiosis. The claimant has not established a mistake of fact. The claimant has does not have pneumoconiosis, as defined by the Act and Regulations. The claimant is totally disabled. His total disability is not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER[22]

It is ordered that the claim of F. J. O. for benefits under the Black Lung Benefits Act is hereby DENIED.

A

RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or

[22] Section 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

receipt by) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[23] At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter to **Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210**. *See* 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Notice of public hearing: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 923(b)); 20 C.F.R. § 725.464. Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). Although 20 C.F.R. § 725.477(b) requires decisions to contain the names of the parties, it is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.

[23] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.